Alaska Medicaid

Botulinum Toxin Prior Authorization Form

Physician Providers please note ** below

MAGELLAN MEDICAID ADMINISTRATION

Physician Providers from Office supply (J-Code Billing) – Fax request to: ACS @ (907) 644-8131
^ *Procedure codes, Date of Service, and ICD-9 fields are required fields for physician providers.*
Pharmacy Providers - (Drug to be dispensed from Pharmacy) Fax request to: (888) 603-7696 Phone (800) 331-4475
Incomplete requests will be denied until all required information is received.
Note: *This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form.*
Form available: http://www.hss.state.ak.us/dhcs/pharmacy/medpriorauthoriz.htm Revised10-2011

REQUESTOR	Requestor Name*(Print)*		Title
RECIPIENT	Last Name, First Name, Middle I.:		
DOB:	Recipient ID:		Sex: ☐ Male ☐ Female
PRESCRIBER	Name:		NPI: - - - - - - - - - -
Phone: ( )			Fax: ( )
Specialty:			Proc Code^ / DOS^:
PHARMACY	Name:		NPI: - - - - - - - - - -
Phone: ( )			Fax: ( )
REQUEST	Drug:		Strength: Dosage Form
Primary Diagnosis		ICD-9 CM^:	Dosage schedule:
Other Diagnoses:			QTY Day Supply:
RATIONALE FOR PRIOR AUTHORIZATION			Prior Authorization start date:

1. How old is the patient?

[ ] <12 years old **[ ]** 12-17 years old **[ ]** ≥ 18 years old

2. The patient is being treated for which of the following:

	YES	NO
A. Cervical Dystonia	**[ ]**	**[ ]**
B. Upper Limb Spasticity	**[ ]**	**[ ]**
C. Strabismus	**[ ]**	**[ ]**
D. Severe Axillary Hyperhidrosis	**[ ]**	**[ ]**
E. Blephrospasm	**[ ]** ***Answer question 3 below***	**[ ]**
F. Chronic Migraines	**[ ]** ***Answer question 4 below***	**[ ]**

3. If the patient is being treated for blephrospasm please answer the following: **YES** **NO**

A. Is the patient unable to open their eyelid(s) or functionally blind due to dystonia? **[ ]** **[ ]**

B. Are you the ordering neurologist or ophthalmologist? **[ ]** **[ ]**

If NO, please submit the plan or chart notes from the ordering neurologist or ophthalmologist with this request.

4. If the patient is being treated for chronic migraines please answer the following: **YES** **NO**

A. Does the patient have headaches ≥ 15 days per month? **[ ]** **[ ]**

B. Is the patient on a medication regimen for migraine prophylaxis? **[ ]** **[ ]**

If YES, please list the regimen: _____

C. Are you the ordering neurologist? **[ ]** **[ ]**

If NO, please submit the plan of care or chart notes from the ordering neurologist.

Prescriber's Signature:_____ **Date:**_____